Re: Variations in Hospice Use Among Cancer Patients

Numerous studies have been done to analyze hospice use among terminally ill patients. The recent study by Keating et al. (1) analyzed variations in hospice use among cancer patients. I applaud their efforts but wish to highlight other factors that could have been considered to make the results more comprehensive. The authors reported that the rate of hospice enrollment varied by the race of the principal physician. However, it is unclear whether they also analyzed the enrollment rates among patients who were treated by a physician of the same race as the patient, i.e., did the enrollment rates still differ when the patient and the physician shared a common ethnic background. The literature suggests that patients and physicians communicate more effectively when they belong to the same racial group (2), and this sharing of ethnic background could have an impact on patient decision-making process. Given the cultural and language barriers that exist in the US health care system, some patients may refuse to take medical assistance from a health care provider who does not share the same ethnic background as the patient. Also, some patients may not divulge vital information, such as drug allergies and medication adherence, to a health care provider of different ethnicity and thus appear uncooperative during counseling sessions.

It has been reported (3,4) that patients belonging to minority ethnic groups are not completely aware of the available hospice facilities because of the existing cultural and language barriers. Keating et al. did not report the initial level of awareness of the hospice eligibility criteria among the patients who were enrolled in their study. Patients with a previous knowledge of hospice eligibility criteria may show higher enrollment rates than patients with no previous knowledge of hospice enrollment criteria, thus creating a potential bias. Also, the authors did not clarify whether other health care providers, such as pharmacists and nurses, counseled the patients about hospice enrollment during the study period.

Such counseling could have created a potential bias.

Future studies that examine hospice use by cancer patients on different health coverage plans (including patients on federal plans such as Medicare and Medicaid) and that attempt to identify possible barriers to hospice enrollment in patients suffering from different types of cancers will be important.

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References

Response
Mr Kachroo questions whether racial and ethnic concordance between patients and their physicians might be associated with hospice enrollment, given that previous studies have suggested that communication may be better in racially concordant physician–patient dyads than in racially discordant dyads. Although we found no differences in hospice enrollment based on race of the patient or the physician, we had not previously examined whether racial concordance was associated with hospice enrollment.

In response to Mr Kachroo’s letter, we identified racially discordant and racially discordant dyads in our cohort. Of the 3085 patients in our study, 2045 (66.2%) were in racially discordant patient–physician dyads; however, the vast majority of these pairs (N = 1989) were white patients with white physicians. The remaining discordant pairs included five Hispanic patients with Hispanic physicians, nine black patients with black physicians, and 42 Asian patients with Asian physicians. Hospice enrollment did not differ for racially discordant versus racially discordant dyads (65.3% versus 66.1%; P = .63); however, this analysis is limited by the small number of black, Hispanic, and Asian patients who had physicians of the same race.

Mr Kachroo also suggests that patients of minority ethnic groups may lack awareness of hospice due to cultural and language barriers. Because we did not survey patients directly, we did not have information about patients’ awareness of hospice or about whether other health care providers, such as pharmacists and nurses, counseled patients about hospice enrollment. Our finding of equivalent rates of hospice enrollment across racial and ethnic groups, however, suggests that cultural and language barriers to hospice enrollment were not insurmountable for the minority patients in our study. Nonetheless, we agree with Mr Kachroo that examining how such factors influence hospice enrollment will be important to better understand area-level variations in hospice enrollment.

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